This is an author-produced PDF of a chapter accepted for publication in
Ruth E Board et al (eds), *End of Life Choices for Cancer Patients* (EBN Health 2020)
https://www.ebnhealth.com/index.php/shop/end-of-life-choices-for-cancer-patients

Chapter 4: Patients, physicians and law at the end of life in England and Wales

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1. Introduction

This contribution has two objectives. The first is descriptive: I provide a brief account of the legal status of a variety of end of life decisions or interventions in England and Wales, including refusal of life-prolonging medical treatment, stopping of eating and drinking (SED), withdrawal or withholding of life-prolonging treatment, euthanasia and assisted suicide. To help set the law in a clinical context, I have included a series of hypothetical cases that a cancer specialist might find challenging if encountered in real life. The second objective is more critical: I consider the legal basis for medicine in England and Wales and attempt to identify the grounds on which physician-assisted death might be argued to be lawful or unlawful compared with other medical interventions.

Four preliminaries: (1) I make no claims as to the applicability of what I say to jurisdictions within the UK other than England and Wales; (2) for brevity, I shall discuss only the law as it applies to individuals aged 18 years and over; (3) again for brevity, I omit discussion of the conferral of lasting powers of attorney; (4) readers should note that by physician-assisted death I mean physician-administered voluntary euthanasia, or physician-assisted suicide. I shall distinguish the former from other kinds of euthanasia in due course.

2. End of life decisions and interventions and English law

I shall first outline English law as it relates to refusal of life-prolonging treatment, SED, and withdrawal or withholding of life-prolonging treatment. These end of life decisions share common ground, insofar as they involve some combination of a physician offering or not offering medical treatment and a patient consenting to or refusing treatment or being unable to consent or to refuse. I shall then summarize English law on euthanasia and the encouraging or assisting of suicide.

2.1. Refusal of life-prolonging treatment

Here our concern is the legal status of the conduct by which a patient declines an intervention offered by a medical professional. A contemporaneous refusal of treatment (or indeed a contemporaneous consent to treatment) is legally valid if the following criteria are met: (1) the physician has informed the patient 'in broad terms of the nature of the procedure';[1] (2) the patient has decision-making capacity, which is governed by the Mental Capacity Act 2005 (MCA 2005), sections 1–3; and (3) the patient's decision is voluntary.[2] If a patient's refusal of treatment lacks validity, it may be lawful to provide treatment, provided that the

physician has taken reasonable steps to establish whether the patient lacks capacity, that the physician reasonably believes that the patient lacks capacity, and that the physician reasonably believes that the treatment is in the patient's best interests (MCA 2005, sections 5 and 4).

It is incontrovertible that unless an adult is subject to compulsory treatment under the Mental Health Act 1983, her valid refusal of medical treatment is legally effective. Put another way, the general rule is that overriding a valid refusal of treatment is unlawful, that is, it is a civil wrong (tort) or a crime;[3] the common law (the body of law expounded by judges) takes the *prima facie* inviolability of the person as a fundamental principle.[4] Treatment over a valid refusal is also likely, in the case of physicians engaged in NHS activity, to amount to an unlawful infringement of personal autonomy, which is an aspect of the right to private life protected by article 8 of the European Convention on Human Rights (ECHR) (Human Rights Act 1998 (HRA 1998), sections 6 and 7).[5] Box 4.1 provides a worked example in respect of (contemporaneous) refusal of life-prolonging treatment.

An advance decision to refuse treatment is a decision taken by a person who has decision-making capacity to refuse medical treatment in a future situation in which: (1) she lacks capacity; and (2) a physician wishes to provide the unwanted treatment. The MCA 2005 governs advance decisions to refuse treatment. A key principle of the Act is that 'a person must be assumed to have capacity unless it is established that he lacks capacity' (MCA 2005, section 1(2)). This principle applies as much to advance decisions as it does to contemporaneous refusals of treatment.

A valid and applicable advance decision to refuse treatment has identical legal effect to a valid contemporaneous refusal of treatment (MCA 2005, section 26(1)). Overriding a valid and applicable advance refusal of treatment is unlawful, that is, it amounts to a tort or a crime. In order for an advance decision to refuse treatment to be valid, an individual must not: (1) have withdrawn their decision (MCA 2005, section 25(2)(a); section 24 sets out the modalities for withdrawal (and alteration)); (2) have created a lasting power of attorney *after* the advance decision was made that covers the same subject matter (MCA 2005, section 25(2)(b)). For example, if a person makes an advance decision to refuse cardiopulmonary resuscitation and later makes express provision for the donee of her lasting power of attorney to take all decisions in respect of life-prolonging treatment, the advance decision ceases to be valid; and (3) have done 'anything else *clearly* inconsistent with the advance decision remaining his fixed decision' (MCA 2005, section 25(2)(c)). Whether an individual's behaviour amounts to clear inconsistency requires the exercise of judgement. A good example might be a member of the Jehovah's Witness religion making an advance decision to refuse specific blood products but later renouncing her faith.

A number of factors are relevant to whether an advance decision to refuse treatment is applicable. First, an advance decision is not applicable if an individual is able contemporaneously to consent to or refuse treatment (MCA 2005, section 25(3)). Second, the treatment refused must be the treatment offered and the circumstances in which the treatment is refused must be the circumstances in which the treatment is offered (MCA 2005, section 25(4)(a) and (b)). For example, if a person's advance decision refuses cardiopulmonary resuscitation, but surgery is on offer, the advance decision is not applicable. And if a person's advance decision refuses a blood transfusion in the event that she has dementia, but she has no ongoing neurological disorder and has been involved in a road traffic collision, the advance decision is not applicable. It is important to note that the treatment refused and the circumstances in which the treatment is refused may be specified in lay terms (MCA 2005, section 24(2)). Third, an advance decision is not applicable if 'there are reasonable grounds for believing that circumstances exist that P [the patient] did not anticipate at the time of the advance decision and that would have affected his decision had he anticipated them' (MCA 2005, section 25(4)(c)). Perhaps a classic example of unanticipated circumstances is unforeseen developments in medical treatment (MCA 2005, Code of Practice, paragraph 9.43).[6] Thus if a person refuses what they expect to be very burdensome treatment, but developments in technology have changed the benefit–burden profile, an advance decision may not be applicable. Finally, an advance decision is not applicable to life-prolonging treatment unless certain conditions are met. The individual must state in her advance decision that she refuses treatment even if her life is at risk (MCA 2005, section 25(5)(a)). And her advance decision must be: (1) in writing; (2) signed by her (or by another person in her presence and acting at her direction); (3) witnessed by a third party – not the same person who signs at the individual's direction; and (4) signed by the witness in the individual's presence.

Box 4.1 Refusal of life-prolonging treatment.

A 45-year-old woman with breast cancer metastatic to lymph nodes, bone and liver was treated with combination chemotherapy. Initially, she responded well to treatment and obtained a partial remission with good quality of life. This was sustained for 15 months, when she began to develop new symptoms suggestive of recurrence. Reassessment investigations confirmed that she had relapsed at all of the known sites of her disease. Her oncologist offered her a second-line combination chemotherapy, indicating that there was still a good chance that it would reduce the volume of her metastatic disease, improve her symptoms and prolong her life by a few months. They discussed the experience of treatment, the schedule and time commitment required, and the potential for toxicity, including the risks of major toxicity or treatment-related death.

The patient decided to decline second-line chemotherapy and asked that, as has already been considered, she be referred to the palliative care team for symptom control and appropriate end of life care. Her decision was motivated by her wish to spend as much time with her young family as possible. This would be achieved by avoiding hospital trips and the risk of hospitalization.

Is the oncologist obliged to accept a patient's decision to decline a treatment that has a good chance of prolonging life?

The clinician must satisfy herself that the patient's decision is legally valid. She has explained in broad terms the nature of the procedure. The patient is presumed to possess capacity and appears able both to receive the information and process it, and to express her views clearly. There is no evidence that the decision has not been taken voluntarily. As the legal criteria appear to have been met, the patient's decision is legally valid and must be respected. The oncologist and members of the wider multidisciplinary team should support her in her decision.

2.2. Stopping of eating and drinking

Although not inherently a medical decision, the pursuit of SED may bring the patient into contact with medical professionals. A patient may decide to refrain from oral ingestion of food and fluids, which is met by an offer to provide clinically assisted nutrition and hydration (CANH) on the part of her physician (or indeed consideration of involuntary feeding by the latter). Or a patient may be in receipt of CANH but wish to refuse it henceforth. Or a patient may wish to receive palliative care, for example, analgesic, antipsychotic or sedative drugs, to improve her dying process.[7] From either of the first two examples the parallel between SED and refusal of treatment emerges: the offer (or contemplation) of medical intervention is met by patient refusal. If an SED decision of this kind is legally valid (the validity criteria are the same as above), it is legally effective in the same way as a refusal of treatment. It is unlawful to feed a patient validly embarking on SED, against her will.[8]

The legal status of support for SED in England and Wales is uncomplicated: it is lawful. The law denies that refusal of life-prolonging treatment ever amounts to suicide.[9] A decision to pursue SED in the presence of an offer to provide CANH is a refusal of treatment. In law, such a decision does not constitute suicide. Support for SED cannot amount to suicide assistance, legally speaking. Box 4.2 provides a worked example in respect of SED.

Box 4.2 Stopping of eating and drinking.

A 67-year-old man was initially diagnosed with locally advanced colon cancer treated by surgery and chemotherapy. He remained well for 15 months, when routine follow-up investigations revealed abnormal liver function tests and imaging revealed liver metastases. He was treated with second-line chemotherapy, followed by the resection of liver metastases. At the end of the procedure he was disease-free on all investigations. A year later the disease returned in the liver and he was treated again with second-line chemotherapy, but surgery was not considered feasible. He experienced considerable toxicity and, after a brief partial regression of his disease, it progressed steadily, producing bulky metastases with associated pain, jaundice and persistent nausea. He became seriously unwell and expressed a wish to have no further active treatment. He discussed the option of further chemotherapy with his oncologist and in a shared decision they agreed that further systemic anticancer treatment was likely to be of very limited benefit.

The patient's symptoms progressed and he decided that he wished to die. He discussed his decision with his family and clinical team. Following the discussion he decided to stop eating and drinking but asked that the clinical team should undertake all measures to keep him as comfortable as possible. The consultant suggested that the patient would be more comfortable if he received intravenous fluids but the patient did not wish to do so.

Is the consultant permitted to administer intravenous fluids?

Are the team permitted to provide symptom control and supportive care through the period during which the patient declines to eat and drink?

The patient understands the situation and has had the options around systemic anticancer therapy and intravenous hydration explained but declines them. He is presumed to have capacity and there is no evidence to rebut this presumption: he appears able to receive the relevant information, process it and express his views clearly. Similarly, there is no evidence of a lack of voluntariness. The clinical team are therefore not permitted to administer intravenous fluids. They are, however, permitted to provide symptom control until the patient dies or withdraws his decision to refuse nutrition and hydration.

2.3. Withholding or withdrawing life-prolonging treatment

Two important common law principles structure the legal regime for withholding or withdrawing life-prolonging treatment. First, a physician owes her patient a common law duty of care 'to take reasonable steps to keep [her] alive' (*R (Burke) v General Medical Council*, paragraph 32).[10] Second, a court will not

order a doctor to treat contrary to her clinical judgement.[10,11] It is helpful to treat separately patients who possess decision-making capacity and patients for whom capacity is absent, either on a temporary or a permanent basis, when examining the application of these principles.

In respect of patients who possess decision-making capacity, a valid refusal of treatment extinguishes the physician's duty of care in respect of the treatment offered; the physician has no duty to provide said treatment. Indeed, as noted above, it would be unlawful at common law to force treatment. In situations in which a patient possesses decision-making capacity and wishes to receive life-prolonging treatment, the courts have ruled that a failure to take reasonable steps to keep the patient alive would leave a physician open to a charge of murder (*R (Burke) v General Medical Council*, paragraph 34).[10] This may appear to sit uneasily with the principle that a court will not order a physician to treat contrary to her clinical judgement. In fact, it is perfectly consistent. The civil courts will not order a physician to provide treatment. But she may be open to criminal prosecution should she refuse to treat a patient with capacity who wishes to be kept alive. Box 4.3 provides a worked example in respect of withdrawal of treatment in circumstances in which an individual has decision-making capacity.

Box 4.3 Withholding or withdrawing life-prolonging treatment.

A 69-year-old woman was diagnosed with stage 4 non-Hodgkin lymphoma and treated initially with combination chemotherapy. She entered a complete remission. This was maintained for 3 years, when her disease relapsed with rapidly progressive lymphadenopathy and hepatosplenomegaly. Her haemato-oncologist recommended second-line combination chemotherapy and discussed the procedure with her carefully, including the risks of toxicity and the schedule of hospital visits involved. The patient was the principal carer for her husband who was suffering from advanced dementia. She felt that if she spent time away from him it would cause him great distress. She declined chemotherapy and asked for an active programme of symptom control and support at home.

The haemato-oncologist was greatly concerned by the patient's refusal of a treatment that he considered would bring her considerable benefit. He felt that he would be failing in his duty of care were he not to deliver the chemotherapy. He sought legal advice from his NHS trust.

What is the legal advice?

The legal advice states in the event that the patient fulfils the criteria for a valid refusal of treatment. Her refusal of treatment relieves the physician of his duty of care to prolong her life by providing

chemotherapy. He may continue to provide her with general medical care and involve other professionals as necessary to ensure symptom control and end of life care when appropriate.

Concerning patients who lack decision-making capacity, the physician's legal duty to take reasonable steps to keep her patient alive is conditioned by the requirement that treatment for an individual who lacks capacity will only be lawful if it is in a patient's best interests (MCA 2005, sections 5 and 4). When considering best interests, the legal question is 'whether it is in the patient's best interests to give the treatment, rather than … whether it is in his best interests to withhold or withdraw it' (*Aintree University Hospitals NHS Foundation Trust v James*, paragraph 22).[12] This is because the law's commitment to inviolability of the person applies as much to individuals who lack capacity as it does to individuals who possess capacity;[13] that is, there will be circumstances in which withdrawal or withholding of treatment is required because its provision is not in the patient's best interests. For example, treatment may not be in an individual's best interests when it involves an 'extreme degree of pain, discomfort or indignity' (*R (Burke) v General Medical Council*, paragraph 33),[10] or when an individual is in a permanent or minimally conscious state.[9,14] In all cases, physicians tasked with ascertaining the best interests of an individual who lacks capacity must 'look at his welfare in the widest sense, not just medical but social and psychological … [they must] put themselves in the place of the individual patient and ask what his attitude to the treatment was or would be likely to be' (*Aintree University Hospitals NHS Foundation Trust v James*, paragraph 39).[12]

Approaching best interests from a patient-centred and welfare-driven perspective may mean that physicians become legally required to discontinue treatment, contrary to their clinical judgement. It does not entail, however, that physicians are required to treat patients when treatment runs contrary to their clinical judgement (*R (Burke) v General Medical Council*, paragraph 31),[10] subject to the requirement that the exercise of professional discretion is reasonable (*Aintree University Hospitals NHS Foundation Trust v James*, paragraph 22).[12,15] Again, no court will order a physician to provide treatment contrary to her clinical judgement. Moreover, no court will hold that an intervention is in a patient's best interests if there is no physician who is 'ready, willing and able' to provide treatment; speculative applications to the court for determination of best interests will be struck out for abuse of process.[16]

2.4. Euthanasia

Euthanasia involves a person (D) deliberately causing the death of another (P), for P's own good. A classic example of euthanasia relevant to our discussion involves a physician deliberately injecting her patient with lethal medication because it is *better* or *best* for the latter. We may further describe euthanasia as voluntary, non-voluntary or involuntary. Voluntary euthanasia involves D causing P's death, for P's own good, when P

has consented to D's conduct. Non-voluntary euthanasia involves D causing P's death, for P's own good, when P lacks capacity to consent to D's conduct. Involuntary euthanasia involves D causing P's death, for P's own good, when P has refused D's conduct (that is, death is imposed against P's will). Only voluntary euthanasia performed by a physician falls within the rubric of physician-assisted death.

All forms of euthanasia are illegal (that is, constitute murder) in English law (*Airedale NHS Trust v Bland*, page 865).[9] The offence is made out regardless of whether the person who dies consented to the conduct causing her death, or that death was better or best for her; that is, consent is no defence to murder and there is no distinction between euthanasia and less beneficent killing. Box 4.4 provides a worked example in respect of voluntary euthanasia.

Box 4.4 Euthanasia

An 89-year-old man had advanced unresectable recurrent rectal cancer that was producing obstruction at the rectosigmoid junction. He had delayed attending for medical care and the complications progressed to include a perforation producing intractable peritonitis and persistent difficulty to control pain. He was treated with antibiotics and intravenous hydration, but a surgical consultant confirmed that no operation could prevent the leakage of bowel contents into the peritoneal cavity.

The patient understood the situation and considered all the procedures that were options for him. He was particularly distressed by the loss of dignity experienced in association with his extensive intra-abdominal complications. He asked a member of the clinical team if it was possible to have euthanasia.

Are the clinical team permitted to provide euthanasia?

Euthanasia is unlawful in all jurisdictions within the UK. The clinical team are not permitted to provide euthanasia.

2.5. Assisted suicide

Suicide ceased to be a crime upon the enactment of the Suicide Act 1961, section 1. However, the Suicide Act 1961, section 2(1), makes encouraging or assisting suicide a crime. Under the Act, '("D") commits an offence if (a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and (b) D's act was intended to encourage or assist suicide or an attempt at suicide'. An example of physician-assisted suicide that would fall within the scope of the offence is the prescription by a physician of a lethal dose of barbiturates to her patient, which the latter self-administers.

The consent of the Director of Public Prosecutions (DPP) is required for any prosecution for encouraging or assisting suicide (Suicide Act 1961, section 2(4)). In exercising the discretion, the DPP applies the two-stage test contained in the Code for Crown Prosecutors,[17] supplemented by an offence-specific policy on encouraging or assisting suicide.[18] The first stage of the test requires prosecutors to consider whether 'there is sufficient evidence to provide a realistic prospect of conviction' (Code for Crown Prosecutors, paragraph 4.6).[17] If this stage is passed (a case cannot otherwise proceed), the prosecutor must consider whether criminal proceedings are in the public interest. Here, the policy on encouraging or assisting suicide becomes relevant. The policy enumerates a number of factors that tend in favour and that tend against prosecution. These factors principally concern the determination of whether an individual's decision to perform suicide is autonomous.[19] For example, factor 3 tending in favour of prosecution reads, 'the victim had not reached a voluntary, clear, settled and informed decision', while factor 5 tending against prosecution reads, 'the actions of the suspect may be characterized as reluctant encouragement or assistance in the face of a determined wish on the part of the victim'.[18]

In respect of physician-assisted suicide, health professional status is a factor that tends in favour of prosecution, albeit not in and of itself. Factor 14 of the policy on encouraging or assisting suicide states that prosecution is more likely if 'the suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer [whether for payment or not] … and the victim was in his or her care'.[18]

Factor 14 includes the following clarificatory footnote: 'the words "and the victim was in his or her care" qualify all of the preceding parts of this paragraph … This factor does not apply merely because someone was acting in a capacity described within it: it applies only where there was, in addition, a relationship of care between the suspect and the victims [*sic*] such that it will be necessary to consider whether the suspect may have exerted some influence on the victim.'[18]

Again, we can see that the issue is whether the individual's suicide is autonomous, or whether the professional's influence is such that there would be worries that the deceased's decision was not voluntary; that is, it is not professional status alone that is a factor that tends in favour of prosecution for the Suicide Act 1961, section 2, offence. Rather, it is professional status in conjunction with a relationship of care. However, to the extent that it is potentially difficult to conceive of circumstances in which a physician provides *medical* suicide assistance in the absence of a relationship of care, it may be difficult to avoid investigation into the degree of influence exerted on the deceased. For example, it seems plausible that if a physician prescribes medication knowing that an individual will stockpile it and attempt suicide, she does so within the context of a duty of care owed to the patient.

Before moving on, we should note the successive stream of litigation seeking to effect permissive legal change on assisted death since the entry into force of the HRA 1998 in October 2000. The offence-specific prosecutorial policy on encouraging and assisting suicide owes its existence to the decision in *R (Purdy) v DPP*,[20] in which the House of Lords held that the Code for Crown Prosecutors failed to provide sufficient clarity as to the DPP's exercise of discretion to prosecute under the Suicide Act 1961, section 2(4). As such, the interference caused by the prohibition on encouraging or assisting suicide with the right to respect for private life protected by article 8 of the ECHR was not 'in accordance with the law'.[20] The decision in *R (Purdy) v DPP* was made possible by the ruling of the ECHR in *Pretty v United Kingdom* that the right to decide how and when to die is an aspect of the right to private life protected by article 8 of the ECHR.[21] Unsuccessful challenges to the law on assisted death have followed.[22–24] More litigation on the issue of whether the criminal prohibition on assisted death is compatible with article 8 of the ECHR is highly likely. In parallel to activity in the courts, the campaign organization Dignity in Dying is spearheading ongoing attempts to legalize a version of the Oregon model for physician-assisted suicide through Parliament (see, for example, the Assisted Dying (No. 2) Bill 2015-16 and the Assisted Dying Bill [HL] 2015-16). Box 4.5 provides a worked example in respect of suicide assistance.

Box 4.5 Suicide assistance.

A 75-year-old man had locally advanced prostate cancer treated by radiotherapy and hormone therapy. He obtained a useful remission of his disease with good quality of life. Unfortunately, 18 months later the disease in the pelvis progressed, resulting in extensive bone metastases producing painful fractures. He was treated with intravenous chemotherapy and targeted therapy, with very little benefit. He received radiotherapy to painful bone lesions that reduced his pain considerably for several months.

During the period of reasonable symptom control, the patient decided in view of his age, his frailty and his social situation that he wished to travel to a Switzerland where he could lawfully perform suicide with the assistance of an organization that provides this service.

He asks his clinical team if they would prepare a report documenting his case and explaining his clinical status that could be provided to the organization in the jurisdiction in which assisted suicide is lawful. He had no family or friends and he asked the clinical team if they would assist him in booking ambulance-assisted air travel to the other country to receive assistance to die.

Are the clinical team permitted to prepare a report for him to help him make his arrangements?

The clinical team are entitled to refuse to write a medical report for the patient, because of the risk of exposure to criminal liability. The provision of a report is an act capable of encouraging or assisting suicide or attempted suicide. If the report is intended to encourage or assist suicide, the issue of criminal liability will arise. Writing a medical report for the patient also runs the risk of professional regulatory fitness-to-practise proceedings.[25,26]

A patient may request a copy of his medical records, which the clinical team are under a legal obligation to provide. Paragraph 22 of the General Medical Council (GMC) guidance states that compliance with a data subject access request will 'not normally give rise to a question of impaired fitness to practise'.[25]

Some actions related to a person's decision to, or ability to, commit suicide are lawful, or will be too distant from the encouragement or assistance to raise a question about a doctor's fitness to practise. These include, but are not limited to, 'providing access to a patient's records where a subject access request has been made in accordance with the terms of the (Data Protection Act 2018, section 45)'.[25]

The GMC position can be explained by 'legal advice to the effect that a doctor's compliance with a subject access request even if they knew the reason for that request [was to seek assisted suicide] would be too far removed from the act of suicide to constitute encouragement or assistance'.[27] This provides insight into the legality of complying with a request for medical records that a patient intends to use for the purposes of suicide assistance. Such conduct is unlikely to constitute an act capable of encouraging or assisting suicide; it falls outside the bounds of the Suicide Act 1961, section 2, offence.

Are they permitted to help him book his flight with appropriate clinical and ambulance support?

This conduct falls within the scope of the offence of encouraging or assisting suicide. The first stage of the two-stage test would likely be satisfied; that is, there would be sufficient evidence (such as correspondence regarding transit arrangements) to provide a realistic prospect of a conviction. In respect of the second, public interest, stage, the patient's apparently autonomous decision to seek suicide assistance abroad would be a factor tending against prosecution. However, the pre-existing duty of care between the clinical team and the patient would constitute a factor tending in favour of prosecution. Even if it were ultimately concluded that prosecution was not in the public interest, the mere fact of the duty of care will likely result in a police investigation into the conduct of the clinical team.

3. What's so (legally) special about physician-assisted death?

Physician-assisted death, that is, physician-administered voluntary euthanasia and physician-assisted suicide, is unlawful in England and Wales. In this section, I wish to interrogate the idea that, legally speaking, physician-assisted death is special compared with other medical interventions. I consider, through discussion of the *medical exception* (the legal doctrine that 'takes most medical treatment outside … criminal law regulation'[28]) what it is that might make physician-assisted death legally exceptional.

I argue that in terms of patient benefit, the reasons a physician might provide assistance to die may be the same as the reasons she might offer other medical interventions. On this ground, physician-assisted death is not legally special. However, it is possible that physician-assisted death may be legally differentiated from other medical interventions on public interest grounds. It is these latter arguments that require careful specification and evaluation. If it is plausible that physician-assisted death falls within the medical exception, we have reason to think that it ought to be lawful.

I should stress that what follows is a legal argument, as opposed to a moral argument. Of course, the separation between law and morality is not always neat, and the discussion touches on factors that might be thought relevant to the moral permissibility of physician-assisted death and assisted death more broadly.

What is the medical exception? It is important to recognize that the criminal law is of universal application and is *prima facie* applicable to medical conduct. Medical interventions that involve bodily interference or conduct that causes injury would be crimes, often serious crimes, were it not for legal rules that exempt medicine from the criminal law (*R v Brown*, page 266).[29]

A general principle of the criminal law is that consent alone makes bodily interference involving touching but amounting to less than actual bodily harm lawful.[29] A physician does not commit a crime in touching her patient during a medical examination and treatment, because the latter has waived her inviolability through consent. If, during the course of medical intervention, a physician injures her patient (causes actual bodily harm or greater), consent alone does not provide a defence; the conduct is *prima facie* criminal, but the medical exception may render it lawful. Here, injury refers to any event that interferes with the health of the patient, even if she will be better off overall if treatment is successful. For example, injury may include tissue damage from injections or catheterization, wounds from surgical incision, or the main and side effects of chemotherapy. The medical exception makes these instances of injury-causing conduct lawful because there is a public interest in the practice of medicine.

Penney Lewis observes three categories of public interest reasons that may explain why a particular intervention falls within the medical exception: (1) patient-focused – the intervention is better for patients (by which is meant any potential class of patients); (2) public-focused – the intervention is better for the

community (which might include its being better for patients), for example, tissue and organ donation and non-therapeutic research; (3) professionally focused – the intervention accords with accepted medical practice.[28]

I shall focus on the patient-focused and public-focused reasons. While professionally focused reasons may explain why an intervention falls within the medical exception, I am dubious as to whether appeals to accepted medical practice can, in and of themselves, justify or determine its legality. Any compelling appeal to why it is professionally appropriate to offer an intervention must surely rely on patient- or public-focused reasoning. Importantly for my purposes, physicians have no monopoly over what counts as patient or community benefit. We can employ these concepts to evaluate whether physician-assisted death ought to fall within the medical exception, and for what reason.

In respect of patient benefit, the argument is that it is in the public interest for medical interventions that are better for patients to stand outside the criminal law (within the medical exception). Typically, the analysis of whether a procedure is better for patients involves a *welfare-level comparison*. Would an individual be better off in terms of her well-being were she to have the intervention compared with not having it? Implicit in this analysis is the patient's continued existence regardless of whether she receives treatment. For example, the choice whether to have knee surgery may involve the option of surgery with the promise of greater mobility, and the option of reduced mobility without surgery. In the ordinary run of things, this decision involves choosing between states of affairs in which the patient is alive.

It is intuitive that assisted death could be better for some individuals: for example, those who suffer and wish to die, whose suffering is grave and for whom death would be a proportionate response.[30] However, the analysis of whether physician-assisted death falls within the medical exception cannot appeal to welfare-level comparisons; that is, we cannot establish its betterness for patients by thinking comparatively about well-being in the usual way. This is because if an individual receives assistance to die, she will cease to exist; whereas, if she does not, she will, at least for a time, continue to exist. A welfare-level comparison in such circumstances is impossible: it involves comparing existence and non-existence, something and nothing. In order for physician-assisted death to fall within the medical exception, it is necessary to describe how it could be better for patients in a *non-welfare-level comparison* sense. This may be philosophically challenging.[31]

Importantly, however, resort to non-welfare-level comparisons does not make physician-assisted death legally special. There are interventions whose situation within the medical exception can only be explained by appeal to non-welfare-level comparisons. This is the case for life-prolonging interventions as a class. For example, when considering whether surgical treatment for mortal (gunshot, knife, etc.) wounds is better for

patients, we must compare the option of surgery and (it is hoped) living, with the option of not having surgery and dying: we must compare the comparative value of existence and non-existence. Ordinarily, it is lawful to treat mortal wounds because it is better for patients, but the analysis of why it is better to have life-prolonging treatment does not involve a comparison of welfare levels of a person who will exist regardless of whether they have treatment. In sum, the fact that physician-assisted death requires a non-welfare-level analysis of patient benefit cannot exclude it from falling within the medical exception; that is, if assisted death is better for patients, it may be lawful for the same reason that other medical interventions are lawful.

According to the public-focused justification, interventions that are better for the community are in the public interest and fall within the medical exception. As noted above, this includes interventions whose benefit to the individual who undergoes the procedure is questionable, such as tissue and organ donation and non-therapeutic research. In addition, it is plausible that it is in the interest of the community that individuals receive interventions that are better for them. As such, the public-focused justification for the medical exception might be thought to include the patient-focused justification. There is, I would argue, an important qualification to this claim: an intervention that is better for patients cannot be worse for the community in terms of its impact on its members' rights or interests. For example, in the North Carolina case of *State v Bass*, it was (arguably) better for the patient to have his hand anaesthetized (by a doctor) prior to amputation of four digits (by someone else) in order to commit insurance fraud, but it is clearly worse for the community to facilitate such crimes.[32] This constraint on the compatibility of patient- and public-focused justifications for the medical exception potentially points to a basis for legal differentiation of physician-assisted death from other medical interventions.

While physician-assisted death may be better for patients, it might be thought to exert harmful effects on the community. The challenge for proponents of the legalization of assisted death who wish to bring physician-assisted death within the medical exception is to show that it would not be the case, and the challenge for opponents of legalization is to show that it would be the case.

The English courts have identified three principal arguments against the legalization of assisted death, none of which are settled. First, it might be thought that the legal permissibility of assisted death exposes certain populations, for example, individuals who might be exposed to pressure to seek assistance to die or socialized into thinking that their lives are not worth living, to the risk of harm, and that risk justifies disregarding the benefits of legalization for others.[22,33] Second, it might be thought that the legalization of physician-assisted death would undermine trust between patients and doctors.[23] Third, it might be thought that legalization of physician-assisted death expresses or communicates the view that human life under certain conditions may not be worth living, and that it is wrong for the law to express this sentiment (*R (Nicklinson and Another) v Ministry of Justice*, paragraphs 91 and 185)).[22]

I do not intend (and I lack the space) to resolve these arguments here. What is important to note is that none seem to be pressing issues in respect of currently lawful medical interventions – though the second occasionally comes up in various forms in respect of organ transplantation.[34] On the one hand, it is possible that physician-assisted death is legally special because of one or more of these grounds. This would mean that physician-assisted death would be incompatible with the public-focused justification for the medical exception and as such ought not to be lawful for the same reason that other medical interventions are lawful. On the other hand, if none of these arguments have merit, all things considered, physician-assisted death would not be legally special and there we would have a compelling reason to think that it ought to be lawful and treated like any other (lawful) medical procedure. It is necessary carefully to specify and to evaluate each of the worse-for-the-community-based objections to the legalization of physician-assisted death in order to establish the truth.

4. Conclusion

This contribution had two aims. First, I sought to provide an overview of the legal status of a variety of end of life decisions or interventions in England and Wales. Refusal of life-prolonging medical treatment, SED, and withdrawal or withholding of life-prolonging treatment are all lawful in this jurisdiction. Euthanasia and assisted suicide are both unlawful. Second, I explained what makes medicine lawful in England and Wales. I applied analysis of the medical exception – the legal doctrine that exempts procedures involving injury to the patient from the criminal law – to physician-assisted death. I argued that physician-assisted death may be better for patients in the same way as other medical interventions may be better for patients. I also outlined three potential arguments that physician-assisted death might be worse for the community and thus not able to fall within the medical exception: the risk of harm to others; trust in the medical profession; and the purported expression in law that some lives are not worth living. These arguments involve complex empirical or normative matters, but it behoves us to attempt to resolve them and establish whether assisted death has a place in medicine.

5. Acknowledgements

I would like to express my gratitude to Peter Selby, for his editorial support and for drafting the worked examples, and to Penney Lewis, for her editorial comments that improved the argument and its clarity. I would also like to thank Lisa Forsberg, who read drafts of this contribution. The responsibility for errors is mine only.

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